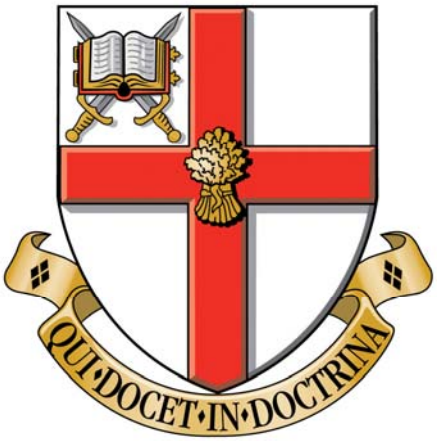

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Title: Providing health care for the homeless population: An evaluation of Chester City Homeless PMS pilot

Date: June 2005

Originally published in:

Example citation: Alford, S., & Perry, C. (2005). *Providing health care for the homeless population: An evaluation of Chester City Homeless PMS pilot. Chester*: University College Chester

Version of item: Published version

Providing health care for the homeless population

An evaluation of Chester City Homeless PMS pilot

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Catherine Perry

June 2005

ISBN: 1-902275-56-X

Acknowledgements

There are a number of people who we would like to thank for their contribution to this research project.

- We would like to thank all those who gave up their time to be interviewed.

- We would like to thank Dr. Martin Dennis for his assistance in organising the interviews with all professionals.

- We would like to thank the homeless support staff for their help in recruiting homeless people for interview.

This project was commissioned and funded by the Cheshire West Primary Care Trust.

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Summary

Background

The health status of homeless people, compared to that of the general population, is extremely poor. One of the main reasons is their infrequent use of health care services, particularly primary care. In 1999, Chester was reported by the Government to have the 15th highest level of rough sleepers in England, and in 2001, a PMS pilot site to provide primary care services for the homeless was established in Chester City. The current study was an evaluation of Chester City Homeless PMS pilot (St. Werburgh's medical practice). It was an exploratory study, designed to evaluate the extent to which the Chester City Homeless PMS pilot had met the needs of the homeless population in Chester by providing an appropriate and accessible primary care service.

Study design and methods

This study was designed using both quantitative and qualitative methods to evaluate the extent to which the Chester City Homeless PMS site had met the needs of the homeless population.

There were three aspects to the study:

- analysis of 'activity contact' information (an 'activity contact' is defined as either a face-to-face consultation with a client, or time spent on behalf of the client with regards to referrals);
- semi-structured interviews with members of the PHCT and other professionals working with the homeless in Chester;
- semi-structured interviews with homeless people.

Twenty-two semi-structured interviews were completed. Sixteen homeless people took part in the study (12 males and 4 females). Six professionals were interviewed. Professional interviewees included the Mental Health Specialist

Practitioner, social and health care worker and GP who work as part of the PMS pilot team, a member of the contact, assessment and resettlement team from a charity for Chester's homeless, a housing and support worker from a charity who are social landlords, and a crime reduction charity worker.

Main findings

Registrations

- One hundred and fifty people were permanently registered clients.
- Eighty-four percent of those currently registered were male.
- Forty-three percent of those people registered were aged between 25-34 years old.

Temporary residents

- Thirty-five people were registered as temporary residents.
- Forty-three percent of temporary residents were aged between 25-34 years old.
- Four hundred and fifteen different clients, either full or temporary residents, were seen between November 2003 and October 2004.

Activity contacts

- There had been a substantial increase in the number of activity contacts made with the clients over the 22 months for which data were available.

Alcohol and drug dependency

- Twenty-seven percent of those registered had problems with alcohol dependency.
- Only sixteen percent of women were recorded as being alcohol dependent.
- Older age groups had a higher *percentage* of alcohol dependent people registered.

- Forty-three percent of all permanently registered clients had problems with drug dependency (42% of males and 48% of females).
- Sixty-five percent of permanently registered clients aged 25 to 34 were drug dependent.
- Drug dependency was a greater problem amongst those from the younger age groups.
- Alcohol was more of a problem with those within the older age groups.

Living situation

- Eleven of the homeless were living in either a hostel or sleeping in the night shelter.
- Five individuals were sleeping rough on the streets of Chester.
- Individuals reported having been homeless for up to fifteen years.
- Fourteen of the homeless interviewees had experienced sleeping rough.
- Reasons for homelessness included mental health problems, the breakdown of relationships, and problems with drugs and alcohol.

Physical and mental health

- The majority of the interviewees expressed concerns over their health.
- Health problems included: stomach ulcers; liver disorders; heart attacks. stroke; eyesight problems; drug related problems; and bad feet.
- Seventy percent of homeless referrals to the MHSP in the previous three months had a co-morbid drug and/or alcohol problem.

Access to and use of health services

- Twelve of the 16 interviewees were registered patients with the St Werburgh's medical practice in Chester.
- Two interviewees were registered with a different practice in the Chester area.
- Only one person stated they had no access to a GP.

Accessibility of primary care services

- The consensus amongst the homeless was that primary care services in Chester were very easy to access.
- Only three interviewees had accessed services at the surgery.

Quality of care

- The quality of care provided by the primary care service was perceived as excellent by the homeless and homeless support workers.
- No interviewees felt there was anything else that could have been done to improve the quality of care.
- Homeless interviewees felt they did not always follow the instructions given by the doctor or other health care professionals.

Consultations

- PHCT were afforded as much time as necessary when dealing with clients, allowing a rapport to be built up.

Staff approaches to care

- PHCT were believed to have a great understanding of the issues surrounding homelessness by the homeless and homeless support workers.
- Homeless support workers perceived the positive attitude of the PHCT as having a decisive impact on the quality of care.

Constraints on service provision

- Members of the PHCT could not identify any real constraint to the service.
- One potential problem was the volume of work created by the increasing numbers of people registering with the service.

Developments

- Counselling services were perceived as a much needed area of development.
- Many of the suggestions for development were outside of the normal primary care remit.
- Homeless support workers suggested additional accommodation is required, especially for those who had been in hospital.
- One homeless support worker felt increased multi-agency working could benefit the signposting of homeless services.
- Working with those who had just become homeless was perceived as a possibility, to help prevent them becoming involved in things like major drug use.

Conclusions

Excellent opportunities to access primary care services are provided for the homeless in Chester, with increasing numbers of homeless people being registered and using the services provided by the PMS site. The positive, caring and welcoming attitude of the PMS site staff would appear to encourage potential users to access the available services.

There is evidence of effective partnerships between the PMS site staff and homeless support agencies to enable those who find themselves homeless in Chester to access primary medical services. However, the problem is those homeless people who do not seek help. Therefore, it is imperative to work with additional agencies in an attempt to reach those homeless people who do not necessarily move in the circles of the homeless. Areas identified for future service development were generally broader than services under the primary care remit, further highlighting the importance of multi-agency working to help ensure the needs of the homeless are being met.

It would appear the PMS pilot is meeting its aim and objectives of delivering appropriate and accessible health services to homeless people. The re-introduction of the MHSP appears to be a key factor for both the PMS site and those agencies that provide support for the homeless. Plans have been made to develop health promotion services, in line with the objectives of the PMS pilot. Therefore, a holistic approach is being taken in meeting the primary health care needs of the homeless in Chester.

Chapter 1

Introduction

1.1 Homelessness, health and health care in Chester

Chester has a large homeless population: in a Government strategy document 'Coming in from the Cold', Chester City was 15th in a table of the highest concentration of rough sleepers in England in June 1999 (Chester City Homeless PMS pilot proposal pro-forma, undated). The health status of homeless people, compared to that of the general population, is extremely poor (Pleace and Quilgares, 1996, in Power et al, 1999). One of the main reasons for the severity of the health related problems that this group experience is their infrequent use of health care services, particularly primary care (Power et al, 1999). In the United Kingdom (UK) as a whole many homeless people have had unsatisfactory or poor experiences of accessing primary care services (Shiner, 1995), often resorting to the use of accident and emergency (A and E) services inappropriately and placing additional cost on the NHS (Crane and Warnes, 2001). This situation is reflected locally in Chester (Barry, 2000), where, although existing primary care service providers have made considerable effort to serve the needs of the homeless population (Chester City Homeless PMS pilot proposal pro-forma, undated), the disadvantages created by their circumstances have meant that traditional General Medical Services (GMS) primary care practices have not been able to provide the range and quality of service needed by the homeless.

The NHS (Primary Care) Act 1997 allowed for the voluntary establishment of different methods for delivering general medical and other services through local, flexible contract agreements, rather than through the then traditional centrally negotiated GMS contract (Leese et al, 1999). This resulted in the establishment of Personal Medical Services (PMS) pilot sites, general medical

practices which negotiated the services they provided at local level, originally with Health Authorities and subsequently with Primary Care Trusts (PCTs). In February 2001, a proposal was put forward, and subsequently accepted, for the establishment of a PMS pilot site in Chester City to serve the needs of the homeless population. This was a locally negotiated contract aiming to address a specific local need.

The service is currently provided by a General Practitioner (GP), Mental Health Specialist Practitioner (MHSP), social and health care worker and nurse clinician all of whom are employed in a full time capacity. The service aims to provide five sessions at the drop in centre each week with the GP; three additional clinics are held in surgery by the GP, with further sessions held in surgery by the nurse clinician. Both the nurse clinician and social and health care worker provide support alongside the doctor with visits to hostels and shelters. Further support to the service is provided by the MHSP.

It is against this background that the current study, an evaluation of Chester City Homeless PMS pilot (St Werburgh's medical practice), was set.

The objectives of Chester's PMS pilot for the homeless were:

- to deliver appropriate and accessible health service to homeless people;
- to deliver measurable improvements in the health of homeless and insecure people in Chester through the promotion of positive health and provision of primary prevention activities;
- to deliver measurable improvements in health of homeless people through the delivery of appropriate health care.

1.2 Research questions

This was an exploratory study, addressing the first objective of the PMS site. It was designed to evaluate the extent to which the Chester City Homeless PMS

pilot had met the needs of the homeless population in Chester by providing an appropriate and accessible primary care service. A steering group was formed consisting of the research and development officer for Cheshire West Primary Care Trust and the GP and nurse clinician from the PMS pilot in order to establish the objectives of the research. The objectives were to:

- explore the views and experiences of homeless people who had and had not accessed the service, in relation to issues such as individuals' perceptions of need, the extent to which needs had been met, accessibility of the service and comparability of the service to any primary care services accessed in the past;
- explore the views and experiences of members of the primary health care team (PHCT) in relation to the ways in which the PMS pilot provided accessible care that met the needs of the homeless population;
- explore the views of other professionals who work locally with the homeless population in relation to the ways in which the PMS pilot provided accessible care that met the needs of this group;
- analyse quantitative data collected by the PMS site in terms of the number of people contact was made with and the reasons for contact.

1.3 Structure of the report

This report is organized into a number of chapters. In Chapter 2 there is a review of literature relevant to this report. Chapter 3 details the study design and methods used. Chapter 4 presents quantitative findings relating to patients using the services, and Chapter 5 presents the findings from semi-structured interviews conducted with both homeless people and professionals. Finally, in Chapter 6 there is a discussion of the findings.

Chapter 2

Literature review

2.1 Introduction

The number of people currently homeless in the UK is on the increase (Shelter 2005) and providing care and support for this group is a key government issue (Reilly, Jones, Gaulton and Davidson, 2004). However, providing health care to those who find themselves homeless is often problematic due to the complex nature of homelessness (Shiner and Leddington, 1991). In order to set this study in context, some of these issues will be explored, with the following areas covered in this literature review:

- incidence of and reasons for homelessness;
- policy responses to homelessness;
- health and health care of the homeless population;
- current health care initiatives for the homeless;
- health care needs of Chester's homeless.

2.2 Incidence of and reasons for homelessness

An individual is defined as homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them (and their household) and which it would be reasonable for them to continue to live in. It would not be reasonable for someone to continue to live in their home, for example, if that was likely to lead to violence against them (or a member of their family) (ODPM, 2002). Homelessness can be divided into two categories: statutory and non-statutory. The statutory homeless are known to and recognised as homeless by local authorities. In total, 100,810 households were recognised as statutory homeless and living in temporary accommodation in 2004 (OPDM, 2004a). Those defined as non-statutory homeless include hostel dwellers, rough sleepers and individuals staying with family and friends (Riley,

Harding, Underwood and Carter, 2003). Whilst organisations have attempted to estimate the numbers of people living in hostels or squatting (Shelter, cited in Riley, 2003), obtaining accurate figures for the true number of people who are affected by homelessness is difficult with people sleeping on the street (rough sleepers) and those who are considered the 'hidden homeless', that is temporarily living with friends and family. Counts of rough sleepers are conducted by local authorities in partnership with local homeless agencies. Chester reported only having one rough sleeper in June 2004, whilst Westminster (175 people), the City of London (22 people), Manchester (18 people), Derby (14 people) and Preston (14 people) head the table for the highest numbers of rough sleeps (OPDM, 2004b). Such attempts to record rough sleepers are conducted on a single evening of the year, thus estimates may not capture the larger number of people who may have experience of sleeping rough over the course of a year. Furthermore, factors such as the weather and the thoroughness of the search on the night can influence recorded numbers.

The main cause of homelessness cited in the literature is parents, relatives or friends no longer willing or able to provide accommodation. This accounted for 37% of all homeless cases in 2003/2004 (ODPM, 2004a). During the same period, 20% of homelessness occurred due to relationship breakdowns, whilst 13% occurred as a result of a loss of private rented accommodation, i.e. the end of a tenancy agreement (ODPM, 2004a). Furthermore, poor health can also result in a person becoming homeless, whilst at the same time ill health is no guarantee of obtaining public rented housing (Power et al, 1999).

2.3 Policy responses to homelessness

Addressing the issue of homelessness is an important part of the UK Government's social policy agenda (Reilly, Jones, Gaulton and Davidson, 2004). Reforms to address health and social care issues for vulnerable and marginalised

groups such as the homeless have been made, creating new financial structures, powers and obligations for local authorities and health care services (Crane and Warnes, 2001). Previously, Local Housing Authorities' (LHA) strategies had been developed to help meet the needs of households unable to purchase or rent accommodation on the open market, including those with special housing needs, for example the elderly and those with mental health problems. However, now measures to help monitor and respond to the needs of the homeless have been introduced, with the Homelessness Act 2002 requiring local authorities to review all homelessness in their area and to develop a comprehensive strategy to tackle it. Under the new legislation, LHA were required to concentrate on the prevention of homelessness and the identification of available resources to be available to deliver this. Government concerns over the number of homeless people have been met with a £150 million pledged to improve the future for the homeless by improving hostels for the homeless, supporting rough sleeps, local authorities and voluntary agencies (ODPM, 2004).

2.4 Health and health care of the homeless population

Homeless people are not a homogenous group, and hence they have varying health and social care needs. However, one thing that has been established is that the health status of homeless people, compared to that of the general population, is extremely poor (Pleace and Quilgares, 1996, in Power et al, 1999). For example, it has been demonstrated that mortality rates amongst the homeless aged 16-64 are 25 times higher than those of the general population of the same age. When examining those aged between 16 and 29 years, mortality rates are reported as 40 times higher than those of the general population of the same age (Shaw and Dorling 1998). As Power (1999, p2) states

> 'homeless people form a diverse group with a wide range of health problem and needs. The stereotypical view of the homeless person as being a white, middle-aged, man with an alcohol problem and sleeping on the street, may still be true in certain areas'.

However, whilst there are many homeless people who have problems with both alcohol and drugs, there are numerous other health issues affecting this group. Common illnesses reported include hypertension, diabetes, peripheral vascular disease, respiratory problems, skin diseases, and liver and renal disease (O'Connell, 2004). There are also concerns about the levels of HIV and hepatitis amongst single homeless people, which has been linked partly, but not exclusively, to the use of drugs or the sex industry (Pleace and Quilgares, 1999). This highlights the need to increase sexual health awareness and provide greater levels of support to help prevent such problems occurring amongst the homeless.

Mental health problems are also prevalent in the homeless population. Westlake and George (1994) reported 30-50% of homeless people suffer significant mental illness, whilst Holland (1996) concluded that up to 65% of homeless people will have experienced some form of mental illness during their life, a figure that increases to 73% amongst rough sleepers. Homeless children and their mothers also have high levels of mental health problems, which can continue even after rehousing has occurred (Vostanis, Grattan and Cumella, 1998).

One of the main reasons for the severity of the health related problems experienced by homeless people is their infrequent use of health care services, particularly primary care (Power et al, 1999). Very few homeless people attempt to access mainstream services and register with a GP, or even consult a GP. Crane and Warne (2001a) reported on 61 residents at a hostel which aimed to help people off the streets: only 32% had accessed a doctor in the previous six months; 59% had not seen a GP for more than five years; and in some cases individuals had not seen a GP for 20 years. A similar scenario was reported by Shiner and Leddington (1991), where 72% of homeless interviewees were not

registered with a GP, 12% were registered with a GP outside of the area and just 16% were in a position to receive treatment through a GP they were registered with. Despite the introduction of projects designed to target the homeless, such initiatives have not necessarily met the need of the homeless adequately. Services delivered through drop in centres, hostels and resettlement programmes using outreach workers have tended to concentrate on crisis management, often at the expense of long term health improvements (Power, et al 1999).

Many reasons why the homeless may not use primary care services have been put forward. Crane and Warne (2001a) include: low self esteem; low prioritisation of health; an inability to recognise the severity of a condition; a fear of doctors; and the appointments systems that are often in place. In the UK as a whole many homeless people have had unsatisfactory or poor experiences of accessing primary care services (Shiner, 1995). Shiner and Leddington (1991) also suggest people fear not being taken seriously due to the fact of their homelessness. Homeless people have reported a need to be listened to, understood and taken seriously. These are issues that have been highlighted by homeless individuals as missing when attempting to use primary care medical services (Partis, 2003). Any bad experiences serve to heighten the perception that the homeless are wasting their own and others' time (Shiner and Leddington 1991).

This situation is exacerbated as it has been reported that GPs are often reluctant to register people who are homeless and indeed they are not obliged to do so (Bunce, 2000). Some GPs fear they will not be able to meet the considerable needs of the homeless (Reilly, Graham-Jones, Gaulton and Davidson, 2004). Often, the treatment of ill health amongst the homeless is hindered by their lack of housing, poor nutrition and absence of a social network, as these are all factors which doctors and medical interventions assume when attempting to promote health (Timms and Balazs, 1997).

Additionally, as some homeless do not attend regularly or return for appointments, sometimes due to moving on, the result can be that primary care practices may fail to meet government set targets such as those for immunisation. As a result, practices can miss out on the financial rewards that come with achieving these targets. Combined with this, the stereotypical images of homeless people being disruptive and aggressive have further exacerbated their marginalisation within the NHS (Bunce, 2000).

With such perceptions, fears and obstacles, it is perhaps not surprising that many homeless people have a tendency to wait until crisis point before seeking medical attention, often relying on the inappropriate use of A and E services (Vostanis, Grattan and Cumella, 1998). In doing so, additional strain is placed on NHS resources: it is estimated to cost £44 to use accident and emergency compared to just £15.49 to access an appointment with a GP (Crane and Warnes, 2001a). Furthermore, without continued access to primary care services, problems arise with a lack of medical records, the only source of information being the individuals own memory (Holland, 1996). Therefore, it can be concluded that it is important in terms of both the health of homeless people and the cost to the NHS that this group are able to access primary care services that meet their needs.

2.5 Current health care initiatives

Across the UK there have been various initiatives set up in an attempt to meet the health care needs of the homeless population, with much of the early work conducted centred on disease prevention rather than health promotion amongst the homeless (Power, 1999a). Crane and Warne (2001a) highlighted one service which was funded to provide appointments within a mainstream practice combined with a weekly clinic taking place in a hostel for the homeless. However, appointments conducted at the hostel ceased after just two months and all services were withdrawn within six months. Whilst no reason is given for the

withdrawal of the service, such a case highlights the difficulties faced when providing primary health care for the homeless in a mainstream setting. As Crane and Warne (2001a) reported, working with homeless people can place strains upon staff and it has proved difficult to recruit staff to work specifically with the homeless.

The introduction of PMS pilots has allowed the targeting of the most marginalised patient groups and enabled a more effective use of other non-NHS organisations (Meads, Riley, Harding and Carter 2004). PMS pilot initiatives allow a more flexible approach to target specific needs, a scheme that has been taken up by a fifth of all GPs (Department of Health, 2001). Through the introduction of services such as drop in clinics held in hostels and day centres, it has helped to increase the accessibility of primary care services to the homeless (ODPM2003). Such an approach has been effective in Tower Hamlets (London), where 1950 patients were registered and treated within the initial three years of opening the PMS homeless medical centre. Sessions provided to facilitate treatment included walk-in clinics every morning along with three additional appointment sessions each week (ODPM, 2003). These services were provided by a full-time nurse practitioner, salaried GP and two registered mental health workers, providing strong links to additional support services. Further success has been seen with a PMS pilot in Exeter using a GP/nurse team, which resulted in an 84% drop in inappropriate use of A and E services during times when GPs were available. Furthermore, through the provision of a community psychiatric nurse, a 76% drop in non-referred presentations to psychiatric support facilities was observed (ODPM 2003). Therefore, it would appear that by adapting the way in which health care services are delivered in order to meet the specific needs of the homeless, improvements in the health and health care of the homeless can be achieved.

2.6 Health care needs of Chester's homeless

The health care needs of the homeless in Chester have been previously explored through a report commissioned by Chester City Primary Care Group in 2000 (Barry, 2000). Prior to the introduction of the PMS pilot, all homeless people seeking medical treatment were required to access their local GP, with whom they should have been registered. From the findings of the report (Barry, 2000) it emerged that the majority of Chester's homeless were registered with a GP, although they were unsure if this was permanently or temporarily, and were satisfied that they could access medical treatment via the official route. Problems were identified with physical health, especially with those sleeping rough, whilst depression and anxiety were also identified as prevalent amongst Chester's homeless. When asked whether their health care needs were adequately addressed, Chester's homeless felt they were being given support although some felt consultations could be longer to help establish the cause of problems. Some homeless people felt attitudes towards them were poor and they were not always listened to (Barry, 2000). Further problems were identified by Chester's homeless including the difficulty in complying with appointment systems due to the chaotic lifestyle of the homeless or the fact they could not handle the environment of a waiting room and found the experience overwhelming, as referred to in the findings of Crane and Warnes (2001). Access to more flexible services with longer hours were suggested by hostel residents, whilst rough sleepers believed 'drop-in' services would be of greater benefit. Such a view was not shared by homeless women who felt mainstream services were adequate for their needs (Barry, 2000).

Chapter 3

Study design and methods

3.1 Introduction

This was an exploratory study designed to evaluate the extent to which the Chester City Homeless PMS site had met the needs of the homeless population in Chester by providing appropriate and accessible primary care services. Both quantitative and qualitative research methods were used.

There were three aspects to the study:

- analysis of 'activity contact' information (an 'activity contact' is defined as either a face-to-face consultation with a client, or time spent on behalf of the client with regards to referrals.);
- semi-structured interviews with members of the PHCT and other professionals working with the homeless in Chester;
- semi-structured interviews with homeless people.

In order to conduct this study ethical approval was sought from the local NHS Research Ethics Committee. The study was considered by them to be an audit so did not require ethical approval. In accordance with NHS Research Governance, permission to conduct the study was also sought from the appropriate NHS Primary Care Trust (PCT). This was granted.

3.2 Analysis of activity contact information

Quantitative information is routinely collected by the PMS site in order to record the number of clients registered, to establish how many contacts have been made with each individual, and the type of treatment provided. Information regarding any major health issues a person may suffer, for example drug dependency or alcohol dependency is also recorded. These data were

provided by the staff from the PMS site in an anonymised form and have been presented in Chapter 4. This serves to contextualise the qualitative work.

3.3 Semi-structured interviews with professionals

In conjunction with the steering group for the study, a list of 'key informants' was drawn up for interview, that is, a list of those who work with the homeless in Chester, both as part of the homeless PMS site and also in other capacities. The former group consisted of the MHSP, nurse clinician, social and health care worker and GP who work as part of the PMS pilot team. The latter group comprised of a member of the contact, assessment and resettlement team from a charity for Chester's homeless, a housing and support worker from a charity who are social landlords, and a crime reduction charity worker, all of whom have regular contact with homeless people. Sampling was therefore purposive, a deliberately non-random method often used in qualitative work which seeks to select people who have knowledge which is of value to the research process (Bowling, 2002). Individuals thus selected were contacted by telephone in order to ask if they would be willing to consent to an interview.

All professional participants were provided with written information about the study prior to the interview (Appendix 1). Participation in the study was by voluntary informed consent, obtained by the researcher prior to the interview (Appendix 2). All interviews took place at a time and in a place convenient to the interviewee. With the permission of the respondents, interviews were audio-taped. Following the interviews, audiotapes were transcribed verbatim and a thematic analysis was completed.

Semi-structured interviews have a 'loose' structure consisting of open-ended questions that define the area to be explored, but will allow the interviewer or interviewee to diverge in order to follow up particular areas in more detail (Britten, 1995). Thus, although the interview topics and questions that lead into

exploring these areas may have been defined initially in relation to the purpose, aims and objectives of the study, the semi-structured format will allow interviewees to express ideas that are important to them, and answers can be clarified and more complex issues probed than would be possible using a more structured approach (Bowling, 2002). Interview schedules were developed for both PHCT staff (Appendix 3) and homeless support workers (Appendix 4).

3.4 Semi-structured interviews with homeless people

The sampling strategy for gaining access to homeless people was also purposive. By accessing homeless people who attended the local day centres and used hostels or shelters it was hoped to access people who had and had not had contact with the services for the homeless provided through the PMS site. Initially, homeless support workers were approached to facilitate an introduction to the sites and potential interviewees. The homeless support workers explained the researcher's presence to their homeless clients and then introduced anyone willing to take part in the research.

All homeless participants were provided with written information about the study prior to the interview (Appendix 5). For those who had problems with literacy the information was read to them and explained by the interviewer. Participation in the study was by voluntary informed consent, obtained by the researcher prior to the interview (Appendix 2). All interviews took place at a time and in a place convenient to the interviewee. This was usually immediately and in all cases on the premises of the homeless support agency. With the permission of the respondents, interviews were audio-taped. If interviewees were unwilling to be audio-taped, hand written notes were made. Following the interviews, audiotapes were transcribed verbatim and a thematic analysis was completed of all interviews.

Semi-structured interviews have been used successfully in the past to explore the views of homeless people in Chester (Barry, 2000). An interview schedule was developed (Appendix 6) based on that used in the health needs assessment of the homeless in Chester that was completed in 2000 (Barry, 2000).

Chapter 4

Registered clients and activity contacts

4.1 Introduction

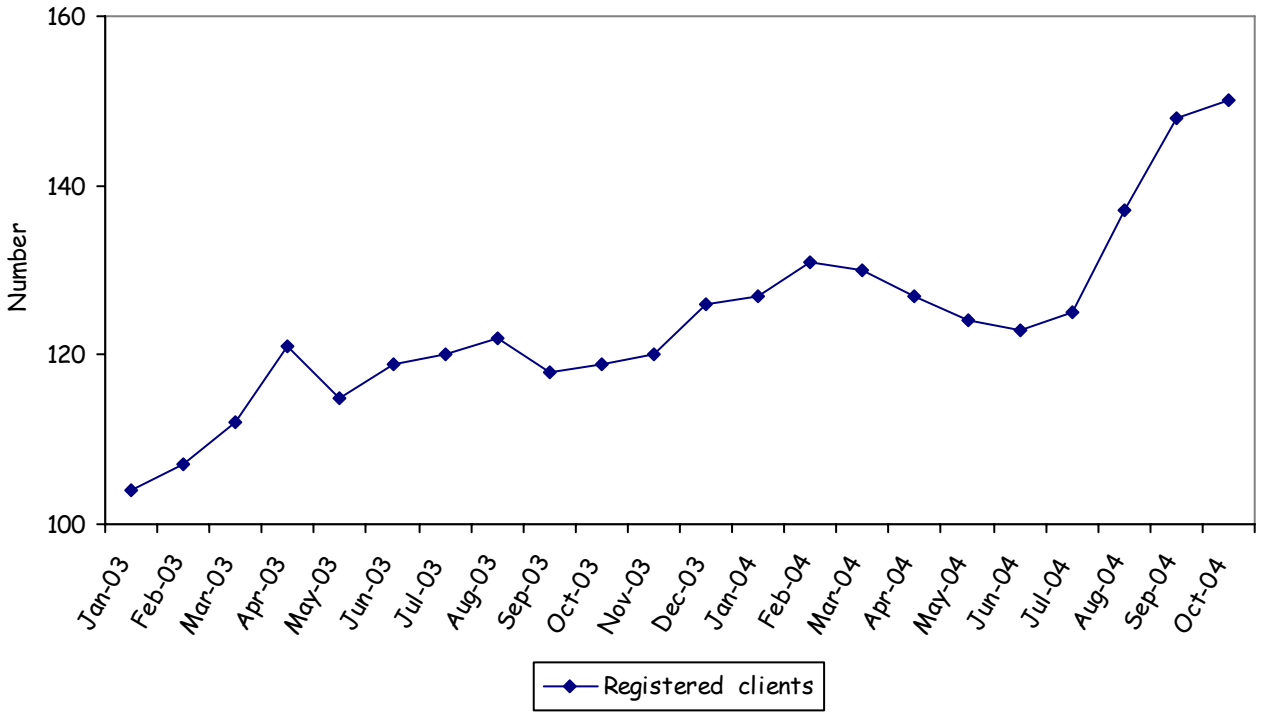
In this Chapter, anonymised data relating to the number of clients registered with the PMS site, and activity contacts, are presented. An 'activity contact' is defined as either a face-to-face consultation with a client, or time spent on behalf of the client with regards to referrals. Registrations can be either permanent or temporary registration depending upon the circumstances of the individual. Data were available for a 22 month period, January 2003 – October 2004.

4.2 Registrations

Clients who were planning to remain in the Chester area and who were regular users of the services were registered permanently with the practice. In doing so, their medical notes were transferred from their previous medical practice, if any. Temporary registrations fell into two categories; firstly, clients who had used the service on only a couple of occasions; and secondly those clients who were resident in local accommodation for detoxification. The majority of temporary residents had a tendency to use accommodation, like the night shelter, for two or three days, or sleep on the streets, before moving on again. For those clients using services like Aqua House, a residential detoxification services, registration allowed those patients to receive treatment for any physical health problems that occurred during their time there.

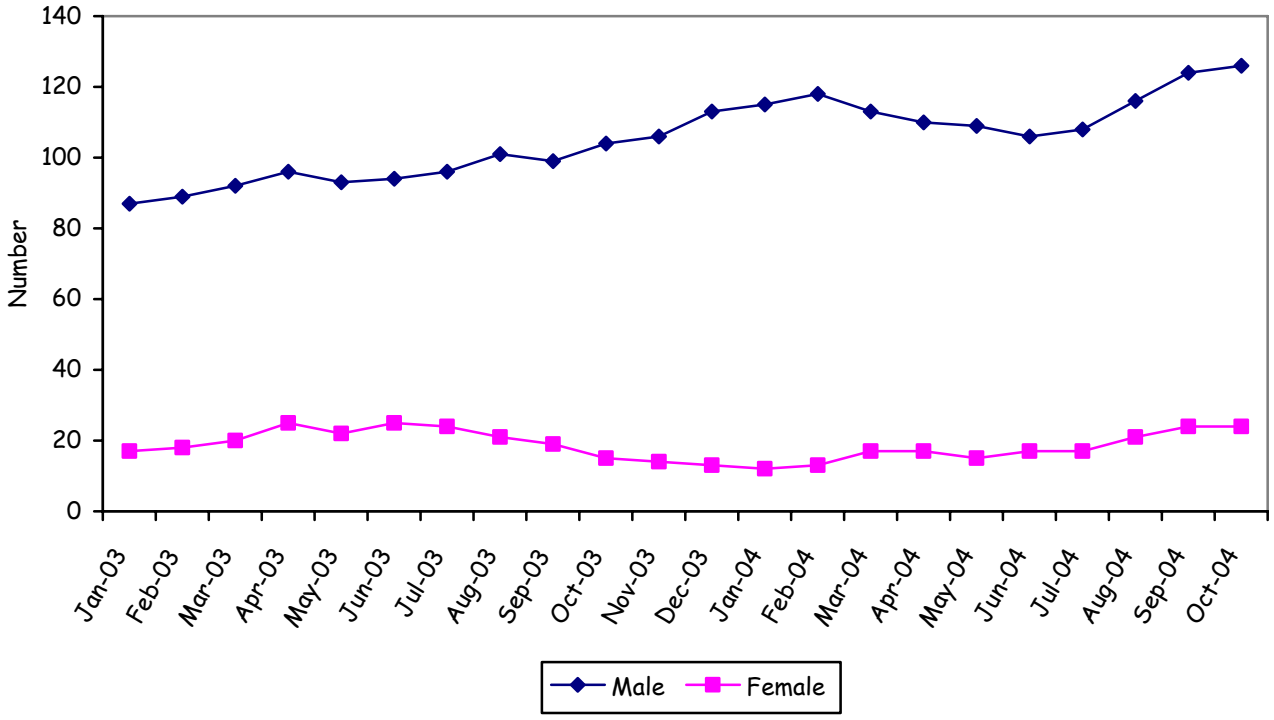
Figure 4.2.1 illustrates the monthly permanent registrations over the 22 month period. There was a steady increase in the number of clients registered with the service, and by October 2004 there were 150 permanently registered clients.

Figure 4.2.1 Permanently registered clients from 2003



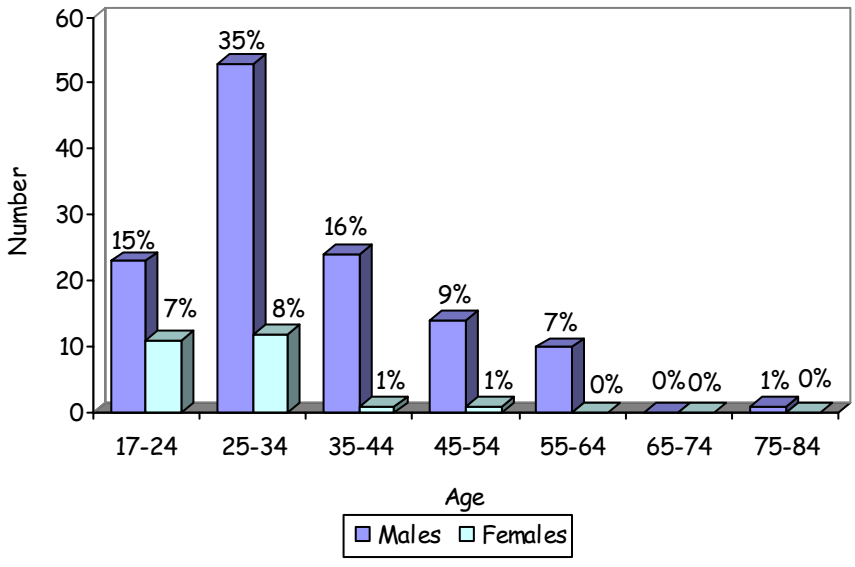
The number of permanently registered clients broken down into males and females over the 22 month period are illustrated in Figure 4.2.2. The number of homeless females registered remained relatively constant over the data collection period. However, the number of males has continued to increase, and 126 (84%) of those currently registered are male.

Figure 4.2.2 Male and female registered clients



The ages of all those permanently registered in October 2004 are displayed in Figure 4.2.3. Of the 150 people registered, 65 (43%) are aged between 25-34 years old, with a further 34 (22%) aged 17-24 years old.

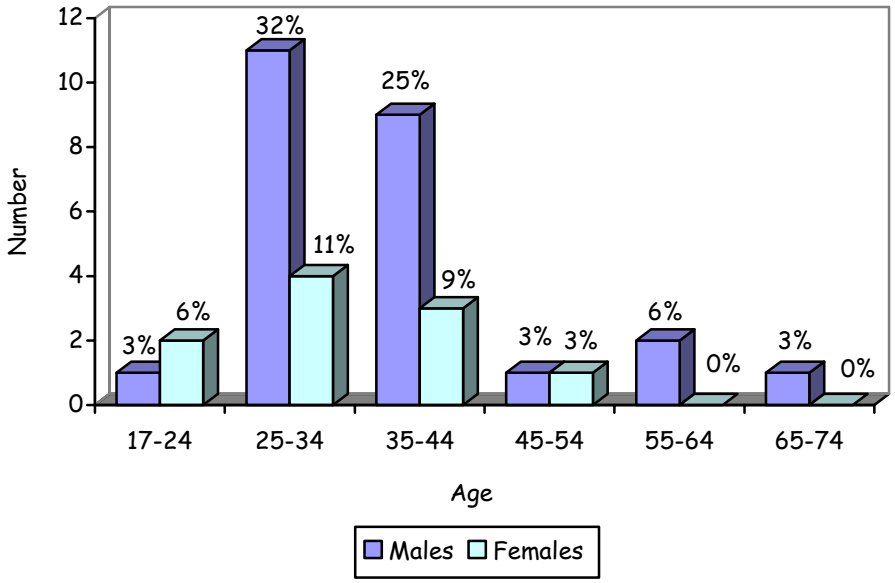
Figure 4.2.3 Age of permanently registered clients, October 2004



4.2.1 Temporary residents

Of the 35 temporary residents registered in October 2004, 15 (43%) were aged between 25-34 years old and 12 (34%) were aged between 35-44 year old.

Figure 4.2.1.1 Temporary residents, November 2004



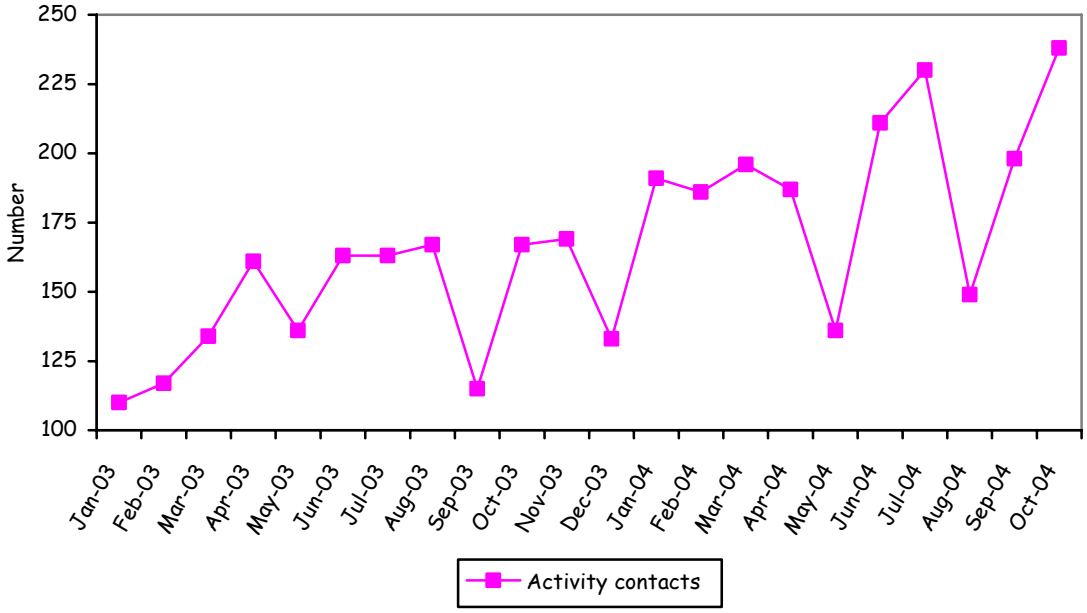
Over the twelve month period November 2003 – October 2004, 415 different clients, either full or temporary residents, were seen at either the surgery or one of the drop in sessions held at facilities for the homeless. The fact this number is so much higher than the 150 permanent registrations highlighting the transient nature of homeless people.

4.3 Activity contacts

Figure 4.3.1 illustrates the activity contacts over the 22 month period for which data were available. Overall, there was a substantial increase in the number of activity contacts made with the clients. It is evident that increases and decreases in the level of activity contacts occurred at various points in time, and in many cases this can be related to aspects of the development of the service. In September 2003, the then nurse clinician left, causing a drop in contacts. In January 2004, a replacement nurse clinician was appointed which

resulted in an increase in the number of clients being seen. The rise in contacts in July 2004 coincided with the practice moving to a new purpose designed surgery and having a full complement of staff. In August 2004 a member of staff became absent from work due to sickness, resulting in a reduction in the number of activity contacts. Despite being a member of staff down, between August and October 2004 the number of activity contacts returned to its previous levels. This increase in activity contacts coincides with the MHSP contacts being entered onto the system, in September and October 2004, for the first time.

Figure 4.3.1 Activity contacts from January 2003



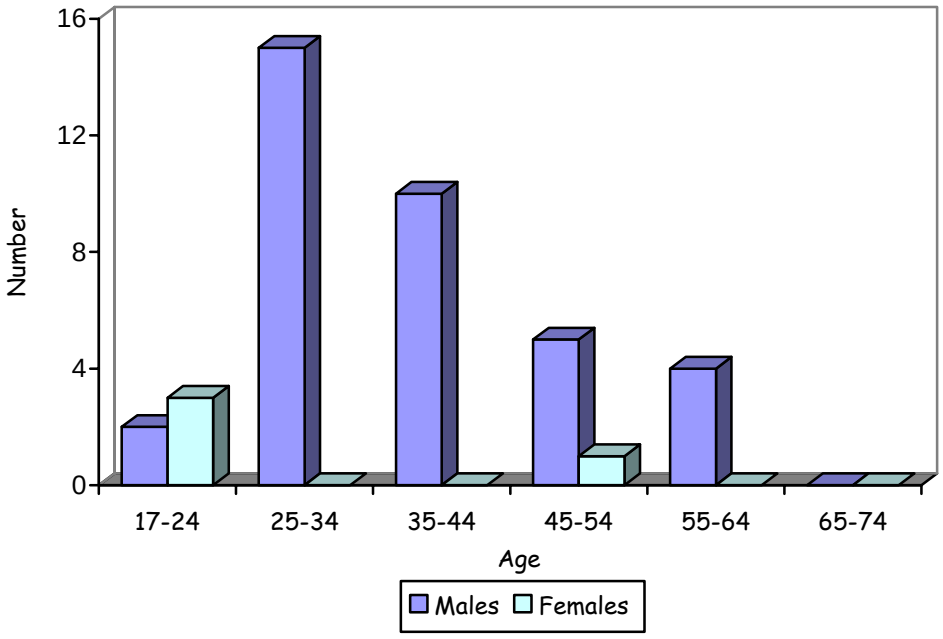
4.4 Alcohol and drug dependency

Clients are screened by the GP for alcohol or drug dependency on the basis of their medical records, using the definition of dependency as 'physical and psychological withdrawal and craving'. Alcohol dependence is recorded for both those who are dependent as well as those who severely binge drink and possibly suffer withdrawal effects as a result. Drug dependence is recorded if clients are in treatment with local

drugs services or if through consultation and/or previous notes there is evidence of drug use of a dependent nature.

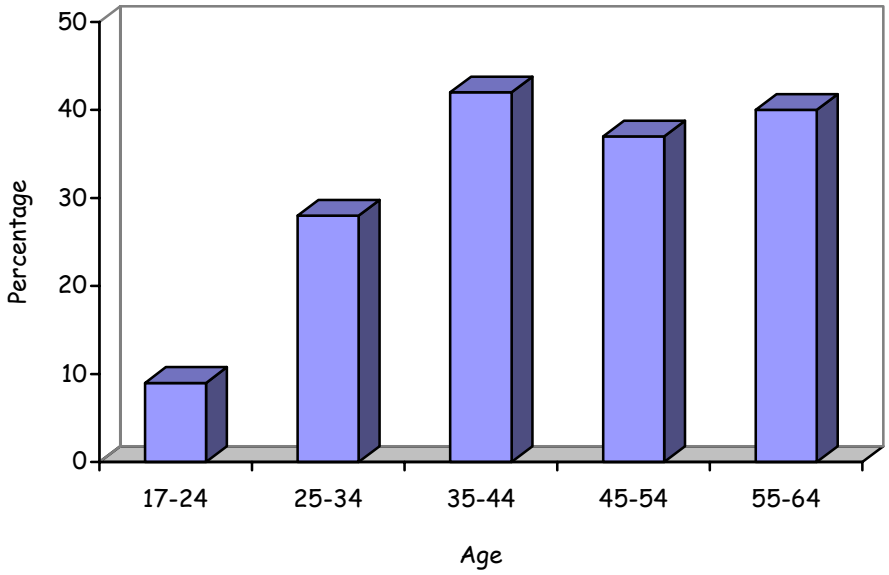
Of those clients registered in October 2004, a high number had problems with alcohol and drug dependency. Forty (27%) of those registered had problems with alcohol. Figure 4.4.1 illustrates the age and gender of those with alcohol problems within the surgery.

Figure 4.4.1 Alcohol dependent clients by age group and gender



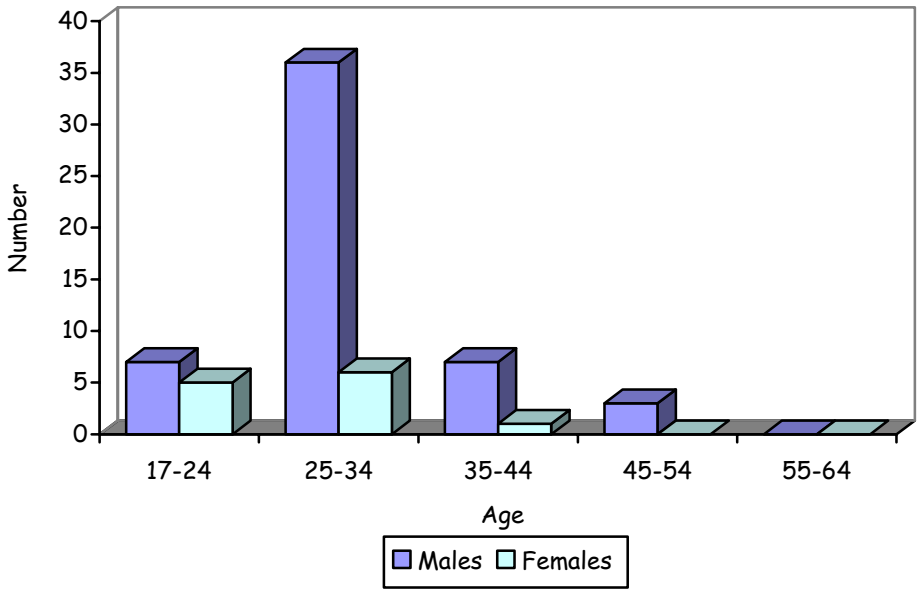
Only four women were recorded as being alcohol dependent. The highest *number* of alcohol dependent individuals were in the 25 to 34 age group, the older age groups had a higher *percentage* of alcohol dependent people registered, as illustrated in Figure 4.4.2.

Figure 4.4.2 Percentage of permanently registered alcohol dependent males within each age group.



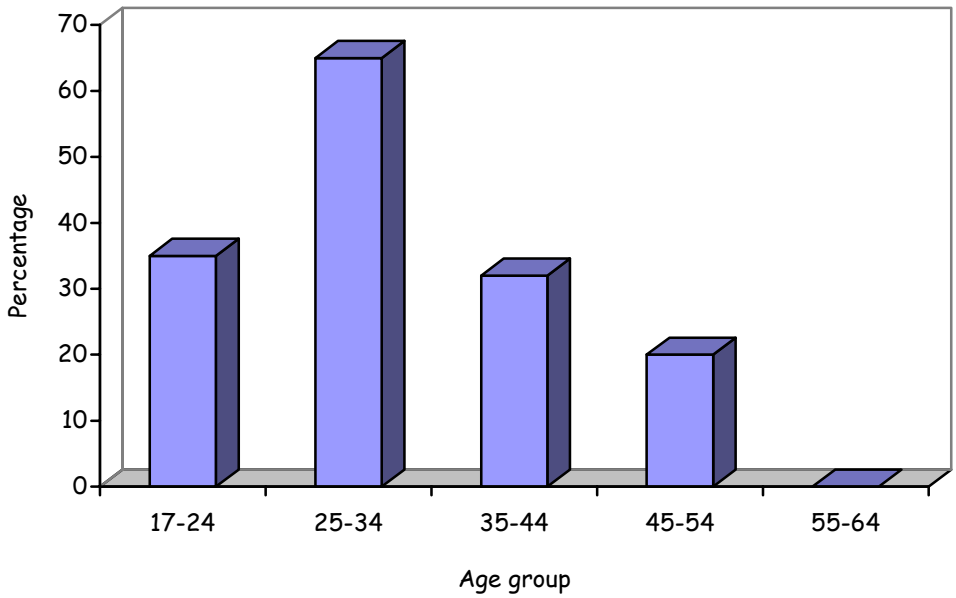
Drugs were a greater problem amongst those people currently registered with the PMS site in October 2004. Forty-three percent of the total of permanently registered clients had problems with drug dependency (42% of males and 48% of females). The highest number of drug dependent clients were males aged between 25 and 34 years, as illustrated in Figure 4.4.3

Figure 4.4.3 Drug dependent clients by age group and gender



When examining the percentage of registered drug dependent clients by age group, sixty-five percent of permanently registered clients aged 25 to 34 were found to have drug dependency, as illustrated in figure 4.4.4

Figure 4.4.4 Percentage of permanently registered clients with drug dependency by age group



These data suggest that drug dependency it would appear that drug dependency is a greater problem amongst those from the younger age groups, whilst alcohol is more of a problem with those within the older age groups.

Chapter 5

Findings from the interviews

5.1 Introduction

During October and November 2004 a total of 22 interviews were carried out with homeless people and with professionals who work with the homeless in Chester. Twenty homeless people who could potentially use the primary care services provided in Chester were asked to participate, and of this group four declined to be interviewed. Consequently, sixteen homeless people took part in the study (12 males and 4 females). Six professionals were also interviewed. These included three members of the PMS site primary health care team: a MHSP; a social and health care worker; and a GP. It had been intended to conduct an interview with the nurse clinician, but this individual was unfortunately not available throughout the duration of the research. Three further interviews were conducted with support workers who provide support for the homeless community: a manager of the contact, assessment and resettlement team for Chester's homeless; the team manager for NACRO in Cheshire who manages projects such as the homeless hostel and housing; and a charity worker who assigns key workers to the homeless whilst providing accommodation and acting as landlord for the homeless.

During the course of the analysis of the interview data a number of themes emerged: living situation; physical and mental health; access to and use of health services; quality of care; constraints on service provision; and future development of services. Quotations from the interviewees are used to illustrate themes, although in order to protect the identities of interviewees quotations are identified by a transcript number.

5.2 Living situation

From the interviews with homeless people it was established that this client group had wide and differing experiences of being homeless. Eleven of the homeless were living in either a hostel or sleeping in the night shelter, including three of the women. The remaining five individuals, four men and one woman, were sleeping rough on the streets of Chester.

All of the homeless interviewees were asked about the number of occasions on which they had been homeless. Varying responses were received, ranging from one person who had just experienced her first night of being homeless, to others who had experienced homelessness continually for significant periods of their lives. In some cases individuals had been homeless for up to fifteen years with time spent on friends sofas ('couch surfing'), sleeping rough and in hostels or night shelters.

The homeless interviewees were asked if at any stage they had slept rough, even if they were currently living in either the hostel or night shelter. Including those who were currently sleeping rough, fourteen clients had experienced this at some point in their life. Of the two who had not experienced sleeping rough, both were women and one had only become homeless the previous day and had been fortunate enough to gain entry into a hostel for women. The uncertain nature of being homeless was highlighted by one interviewee who commented:

> *'Previously I have slept rough on numerous occasions for periods of up to 6 weeks at a time when I've not been able to get a bed in a hostel.' (H1).*

The causes of homelessness varied amongst the interviewees. Reasons given included mental health problems, the breakdown of relationships, and problems with drugs and alcohol. However, for one interviewee being homeless was a choice. He commented:

'I live on the streets. I am homeless. I have been homeless for most of my life but off and on because things failed and the streets are the only place I can feel safe.' (H11).

5.3 Physical and mental health

The majority of the interviewees expressed concerns over their health. Of those who did not express particular concerns, two individuals still identified health problems that they had experienced. One interviewee felt he had no problems with his health, although he did have problems with the amount of alcohol he was currently drinking but still felt he was pretty healthy. Another interviewee felt he had no health problems but stated that he had had problems previously with his eyesight and mental health issues since being homeless for which he had received treatment.

Those interviewees who expressed concerns about their health reported a wide range of problems including: stomach ulcers; liver disorders; heart attacks; stroke; eyesight problems; drug related problems; and bad feet. Often, one person expressed a number of concerns. For example an interviewee commented:

'I've lost four stone, I don't eat much. I had a thrombosis last year on the street, it wasn't drug related it was unknown why it happened. Apart from that I've not had much treatment really. I've had mental health problems in the past but like depression really and had treatment in the past.' (H6).

One professional interviewee commented that there was a lot of drug and alcohol use amongst the homeless community in Chester. This individual stated that nationally 50% of all homeless people are thought to have mental health issues, whilst 70% of those referred to the MHSP at the PMS site in the previous 3 months had a co-morbid drug and/or alcohol problem, making the problem more complex. Other common problems reported by professionals centred on the lack of opportunity to undertake simple hygiene tasks especially for those sleeping rough. Head lice were highlighted as a problem amongst the

homeless in Chester by a member of the PHCT. Bad feet were also a recurring problem caused by continual wearing of the same footwear. This was commented on by a member of the PHCT and a homeless person who was living on the street who had used the day centre service to have such problems attended to by the doctor.

5.4 Access to and use of health services

Twelve of the 16 clients interviewed were registered patients with the St Werburgh's medical practice in Chester. Two interviewees were registered with a different practice in the Chester area. One interviewee who was not registered with a local doctor had only arrived the day before and was due to visit the St Werburgh's surgery, as an appointment had been organised by the hostel. Only one person stated they had no access to a GP and appeared to be dissatisfied with the quality of care available. However, an appointment had been arranged by night shelter staff for this person to see a doctor but he failed to attend.

In terms of access to and use of health services, interviewees made comments relating to the accessibility of primary care services, factors that make accessing primary care services problematic and comparisons with other towns and cities.

5.4.1 Accessibility of primary care services

The consensus was that primary care services in Chester were very easy to access. For example, one interviewee commented:

> *'I would say very easy in comparison to when I wasn't homeless, or easier in fact. I had been living prior to coming to Chester, I had lived in a village which is about 12 miles from here. I was registered with a GP there. It was fairly easy but you might have to wait two or three days to get an appointment whereas here you can just get one more or less on the same day really.' (H9).*

The ease with which homeless people can 'access' primary care services was further explained by another interviewee who commented:

> *'These doctors at the day centre they ……..which is good because you are either there to see a doctor or you are not there. So if you miss him you have not got to wait another week to see him or whatever. But at least you know that it is there. If you go to see a normal doctor you have got to wait 8 hours of whatever or next week or something like this. So this is better than what a normal doctor is.' (H11).*

The view of an easily accessible service was supported by all professionals. As one professional commented:

> *'You can see a doctor in a minute if you really need to see a doctor. You can see the mental health therapist you know in half an hour, you know which is unprecedented in the rest of the general population. I think the impact has been enormous for them.' (P6).*

Of the homeless interviewees, only three had actually accessed services at the surgery, with the majority accessing treatment through the day centre or a visit in the hostel. It was perceived by the homeless that, through services being held in places like the day centre, rather than their having to 'visit the doctor', this system was 'easier'.

In addition it was felt by professionals that the convenience of the drop in centre played a major part, especially with its location close to the night shelter. Some interviewees commented upon the difficulty accessing traditional primary care services such as doctors' surgeries. If homeless people are sent elsewhere to receive treatment there is the possibility that they may not comply with these instructions due to the chaotic lifestyle, therefore failing to receive the appropriate care. Furthermore, homeless people may perceive themselves not to be 'normal' and feel uncomfortable in the 'normal' situation of a surgery waiting room. For example one interviewee commented:

'Well I think the service of the day centre here is excellent. I think if people were then here looking for a doctor and they were sent somewhere else, then they may not go. Some people would be reluctant to go to a normal doctor's surgery for their own reasons.' (H9).

Another interviewee commented on their visit to the surgery:

'Yes I have, yes. Only once though. I just feel strange because there are normal people there.' (H11).

The St Werburgh's surgery is available for the homeless and provides an alternative venue to the day centre. Not all homeless people felt comfortable using the day centre: some of them tried to avoid some of the other users of the facility for personal reasons. There were also those homeless people who were barred from using the day centre, but who were permitted access solely for the medical services held there. It was suggested by members of the PHCT that there was a fifty–fifty split in the number of people willing to attend the surgery, just as there was with those willing to use the day centre. Thus the importance of providing a diversity of opportunities for the homeless people to access primary care services is highlighted.

A factor which emerged from the interviews with homeless people living in hostels and/or using the day centre was the effort made by the professionals they encountered to help them access the available health services. Staff of the day centre and hostels attempted to ensure that homeless people using the facilities were aware of the primary care services available. Support workers often made appointments or accompanied people to appointments to ensure they received treatment when needed. The majority of interviewees had received support from either the day centre or hostel staff in accessing medical care.

5.4.2 Factors that made accessing primary care services problematic

Homeless interviewees referred to their inability to keep to appointments as a problem in accessing primary care, often due to the chaotic nature of their lifestyles. Some interviewees were busy and/or forgot about the drop in session held at the day centre. One interviewee expressed confusion about the time of an appointment at the surgery and how she had missed appointments previously. She commented:

> *'Yes, Yes. I've actually got an appointment I think, I don't know the date but the staff are sorting it for me because a bit of trouble… I missed my last appointment.' (H14).*

Another interviewee explained why he had missed an appointment with the doctor:

> *'I was supposed to go last week but I got a bit too drunk and couldn't be bothered. Is it easy to see a doctor: yeah 11 o'clock in the day time.' (H5).*

A problem that was identified by a homeless support worker was ensuring that all homeless people in need of primary health care were aware of the services available to them. This was perceived as especially important for those homeless people who choose not to socialise in the circle of the homeless community. As one professional commented:

> *'There are the services out there and most of them like I say either through being in somewhere like this (hostel) or …..or whatever, or contact with the day centre, it is a good service I say. Some homeless people may not have the information where to go. So apart from those few who may not share accommodation with other homeless people and don't have access to the help we can offer, I would say it is quite good.' (P3).*

5.4.3 Comparisons with other towns and cities

Six homeless interviewees had experienced being homeless in a number of different towns and cities including London, Swindon, Derby, Newcastle,

Manchester, Blackpool and Liverpool. The majority of those who had experienced homelessness in other towns and cities expressed the view that it had not been easy to access medical services and that doctors did not really want to know. The view that medical services were not as readily available in other towns and cities was also articulated by a professional. This professional referred to her employing agency being a national organisation and commented on conversations with colleagues from other areas. This interviewee stated:

> *'We talk about the provision we have got in Chester, nobody can believe that we have got such good provision because certainly with things like mental health issues when I know, I think in Holyhead there was one recently, where there was a guy desperately needed a mental health assessment and they just couldn't get one. And you are having to try to manage a person in a tenancy who is unable to manage and is in desperate need of more specialist support and you can't get it and it is a horrible situation to be in.' (P2).*

5.5 Quality of care

All homeless support workers perceived the quality of care provided by the primary care service as excellent, going a long way towards meeting the demands of a group with such a wide range of needs.

All interviewees were asked about their perception of the quality of the care they received from the primary care services. Of those who had received treatment through the PMS pilot scheme, all were satisfied with the care they had received and did not feel there was anything else that could have been done to improve the quality of care. As one interviewee commented:

> *'I can't think of anything that would improve the service, it is fine. It's a great service, excellent in fact.' (H1).*

However, it was recognised by interviewees that, due to being homeless and the chaotic lifestyle this often entailed, they did not always follow the instructions given by the doctor or other health care professionals, which in turn could have

consequences for any treatment or plan to improve their health. Interviewees often forgot about follow up appointments or to regularly take medication given to them. This was highlighted by one interviewee who commented:

> *'Everything that I am given for help is available it's just up to me, and if I do that, then everything is fine.' (H3).*

There were two main ways in which the quality of care was discussed: in terms of the amount of time that people could spend in consultations; and the staff approaches to care.

5.5.1 Consultations

One aspect of quality of care that was commented upon by both the homeless people and professional interviewees was the amount of time that members of the primary health care team were able to spend with their clients. Instead of the five to ten minutes normally afforded to people seeking a consultation with a doctor, appointments continued for as long as deemed necessary, often as long as 20 to 30 minutes. Through having longer to deal with clients, staff felt they were able to offer a better service, often just spending time talking things through with a client, a luxury that is not often available to health professionals in mainstream practices. As one homeless interviewee stated, although the doctor did not always give him what he wanted, he always took the time to explain the situation. This was highlighted by a PHCT member who explained:

> *'because we've got more time to do it I can say I'm not going to give you any opiates because this. And 20 minutes later you know I can get them to go out the door feeling like they've had a reasonable discussion with the doctor who's explained why he's not going to do it. Or he's given them some exercises and shown them how to do it and they feel they've been listened to.' (P5).*

Homeless support workers also recognised the importance of the length of time for appointments. There was a perception that it allowed a rapport to be built up

with this often very difficult client group, which was necessary in order to deliver the highest quality of care.

5.5.2 Staff approaches to care

The ability of the PHCT to understand the issues surrounding homelessness was highlighted by both homeless support workers and the homeless themselves. As one support worker commented:

> *"when one stage we didn't have [member of primary health care team] as the CPN and there was another [member of PHCT] who took on the role and s/he actually found it really really difficult as s/he didn't really know what s/he was supposed to be doing and also felt I think s/he didn't really know how to deal with the client group because they were so different from the mental health clients s/he had worked with previously and I think that we've not just got people in the roles we've got what appears to be the perfect people for the roles who really do know how to deal with the clients.' (P2).*

The attitude of staff was addressed by one homeless interviewee, following a bad experience when trying to access primary health care in another city, who commented:

> *'Maybe some doctors have a .....I don't know, maybe they think that homeless people don't deserve access to other doctors and stuff like that or they have a prearranged idea of what a homeless person or they think people who are homeless are automatically on drugs all the time and stuff like that. Chaotic and stuff like that but certainly homeless people do things so they can come to terms with the situation that they are in at the moment. So some doctors .....ideas not be what is right or what is a situation at the time.' (H8).*

A homeless support worker who had supported the homeless with hospital visits further emphasised the view that some doctors do not have the awareness and/or the understanding of the problems associated with the homeless. As the following comment illustrates:

'I feel they perhaps don't have the understanding or they have never had it explained to them, the difficulties of using drugs, the difficulty of getting away from that drug use or alcohol use. And maybe they never will because of the pressure situation they are in.' (P3).

The homeless support workers perceived that the attitude of the staff involved in providing primary care for the homeless in Chester had a decisive impact on the quality of care they provided and also the willingness of homeless people to access the available services. By continually working with the client group it had enabled primary care staff to be more appreciative of the problems surrounding homelessness and offer positive support. This was highlighted by one support worker who commented:

'I think because [members of the PHCT] work with the people more intensely, they get to understand the problems more. The people we have here have been excluded from normal services most of the time and they make an extra special effort to include them and to let them know that they can talk to them, they can ……So I think they have had, probably mainly through [member of the primary health care team] influence, a big impact on the homeless people around here.' (P3).

The ability of the staff to show empathy was perceived as critical in building relationships with the clients. As one member of the PHCT highlighted, anxiety is often felt by both the homeless person and the staff of mainstream practices. As a result, homeless people often fail to receive treatment and/or fail to return for follow-up appointments. However, it was perceived by all the homeless support workers and a number of the homeless interviewees that empathy was a quality possessed and demonstrated by the current staff working at both the surgery and drop in centre. As one homeless support worker commented:

'The fact [member of the primary health care team] is extremely approachable; I think there is a certain amount of trust within the clientele. They will go and see him. They might not always get the answer they want but I think that is a good thing. But he will act quickly and in conjunction with other agencies as well.' (P1).

The approach of the current staff when dealing with clients was further highlighted by another support worker who commented:

'its not only we have the people in place to do the roles, it's the fact that all of them are incredibly good with the client group and very very respectful and treat people with dignity and kindness, which makes a big difference.' (P2).

5.6 Constraints on service provision

When attempting to identify factors that limited service provision, members of the PHCT could not identify any real constraint to the service. However, one potential problem identified by professional interviewees was the volume of work created by the apparently increasing number of homeless people residing in Chester. It was perceived by members of the PHCT that the increase in homeless people could partly be attributed to the good work being undertaken with the homeless in Chester. Such work included an outreach programme for prisoners due for release by the social and health care worker, offering support to those returning to Chester who have no accommodation to return to.

If the number of clients continued to grow it was suggested that additional staff would be required to help meet the increased demands. However, it was felt that once the number of staff had returned to its full compliment they should be able to cope with the numbers currently presenting themselves as homeless in Chester.

5.7 Developments

The medical treatment provided by the PMS service was considered more than adequate by the homeless interviewees and professionals. Areas suggested for improvement and development of care offered to the homeless population in Chester centred around broader health and social care issues.

Firstly, it was suggested that support sessions and workshops offering life skills training could be offered by the PHCT. As one interviewee commented:

> *'I've always been aware of what can make you ill but I suppose for people who aren't aware of what can make them ill a list of things that you shouldn't be doing that make you ill things like that. I suppose workshops telling people how to look after themselves, hygiene, dressing wounds, basic first aid and things like that would be very helpful.' (H4).*

Some workshops were already taking place, run by the social and health care worker, who delivered sessions on head lice. There were also plans to develop sexual health awareness and general health promotion sessions. The need for education amongst the homeless was further highlighted by both homeless support staff and homeless interviewees who felt life skills were also required, especially for those who live in accommodation i.e. a hostel. For example, one member of the homeless support staff commented:

> *'maybe more emphasis on nutrition which I think is a big issue. And the fact that the client group will be probably be complete disinterested in it and mostly people choose to spend their money maybe inappropriately and then don't have money for food is an issue and is a concern. But I suppose for the hostels it would be really good to have somebody who would go in and maybe do cooking and simple and nutritious foods and stuff like that.' (P2).*

Secondly, it was suggested that more accommodation for the homeless was essential in Chester, especially for those who had been in hospital. Circumstances in which an individual left hospital with no accommodation and was

forced to sleep rough could have serious consequences for their health. As a result, the health care needs of the individual were not fully met, with further deterioration in health often occurring which could result in further hospitalisation. Whilst the discharge liaison nurse based at the Countess of Chester Hospital worked with the hostels and shelters it was not always possible to accommodate even the most urgent of cases. As one homeless support worker commented:

> *'It is always really difficult because people obviously are well enough to be discharged but perhaps not well enough to rough sleep. I think there is a need for a kind of interim period there where we can't just assume that people can go into the night shelter because of their medical needs or whatever. I think that that is the real kind of crux of what needs to happen. There needs to be an interim rather than people just using the night shelter when they are straight out of hospital. I think there needs to be some kind of interim accommodation provided through health.' (P1).*

The need to provide suitable accommodation and support for those leaving hospital was highlighted further by one member of the PHCT who commented:

> *'the classic line that goes with this is that the doctor would treat them and then say go home and rest and of course they've got no home.' (P6).*

One area of development suggested by a homeless support worker centred on increasing multi-agency working through increasing the awareness of homeless services amongst agencies who work with this client group. By increasing the awareness of the services amongst agencies such as the police force, this could help signpost those who were in need of medical attention. It was suggested that cards that have already been produced, which contain details of the available homeless services, could be given to additional agencies to help signpost services. As one professional commented:

> 'There are concertina cards that people carry which I suppose would be an idea for the police obviously to carry which shows a list of all the services. And make those available in Courts as well because the homeless people have contact with both the police and the Courts obviously. Just generally getting information out about what is available.' (P3).

One area in which it was perceived that services could usefully be developed was around mental health and counselling. Currently no official counselling services are provided for the homeless. The need for such services was raised by many of the professionals interviewed. As one support service worker commented when speaking about counselling:

> *'I think that has been a concern for me. It is something I have always felt was really important because as I said at the beginning, so many of the clients we see the issues are emotional baggage that they have carried for years and emotional traumas really.' (P2).*

Plans had been made to address this issue, with the social and health care worker, who is a qualified counsellor, devoting a proportion of her time to providing counselling. It was believed by all professionals that the delivery of counselling through the PMS pilot site and staff would be beneficial to the homeless population of Chester. However, it was recognised that it can be very difficult for many homeless people to engage with counselling, requiring considerable efforts from those members of staff involved in the process. As one member of the primary health care team commented:

> *'It's a really difficult area to attack. We have a referral pathway through the primary care mental health teams so if we needed counselling we can get it, in theory. But how do you counsel, counselling is to do with commitment and turning up at places at the right time and being verbal enough sometimes to actually interact with the counsellor. And a lot of the patients won't turn up, won't, aren't able to express their feelings verbally. Which is sometimes why they're in the situation they're in. And they will not trust people.' (P5).*

Clients who were not able to commit to going to a clinic setting due to their chaotic lifestyle would require visits at their own premises, hostel, day centre or even on the streets to allow the process to begin. In some cases this could even require a search of the streets to make contact with a patient.

Finally, to further develop the service, it was suggested by some professionals that time and effort should be spent working with those who had just become homeless, to try to influence their life choices. As one primary health care team member commented:

> *'Maybe if we could do more to prevent the homelessness in the first place and the sort of social, change of focus away from crime and punishment to helping them. We'd like to try and catch people who have been thrown out of home. And not necessarily got as far as drug use in the big way. And in some ways it might make more sense to sort of concentrate on them and get them back into some sort of healthy living routine than try and patch things up once they've hit bottom.' (P5).*

By attempting to provide proactive intervention to those homeless who are 'couch surfing' or living in temporary accommodation, this could help to maintain health before crisis point is reached as occurs with so many of those people who sleep on the city's streets.

Chapter 6

Discussion

6.1 Introduction

In this Chapter, having briefly outlined the strength and limitations of the study, the findings are discussed in relation to both the aim and objectives of the project and the literature reviewed.

6.2 Strengths and limitations of the study

The views and experiences of a variety of professionals who work to provide primary health care and those who provide support to the homeless are presented in this study. It was also possible to interview a number of people who were homeless and who had different experiences of and perspectives on homelessness, important as the homeless are not a homogenous group (Timms and Balazs, 1997). Therefore, it has been possible to build up a picture of primary health care services for homeless people in Chester. In addition, the experiences of the homeless people interviewed reflected that of homeless people in other areas of the country in terms of experiences of homelessness, reasons for homelessness and health problems experienced. Consequently, some of the findings from this study may be generalisable to the wider homeless population. However, it was not possible to interview all homeless people in Chester and one important omission was those who do not move in the circles of the homeless. The views of this 'hard to reach' group, who may not be aware of or access the primary health care services available to them, are therefore not represented.

The quantitative data presented relating to the number of clients and activity contacts helps to contextualise the qualitative work. However, at the PMS site not all members of staff had been trained to use the recording system

accurately and hence the number of contacts presented may be an under-representation of the work carried out. In addition, some contacts occur in the street as a result of a coincidental meeting between a member of the PHCT and a homeless person, and are not always accounted for within the activity contacts. For example, such a meeting was witnessed by the researcher whilst passing through the city centre to visit a hostel with a member of the PHCT. During this contact an assessment was conducted upon a hand injury, but this consultation was not recorded. It is clear therefore that coincidental contacts should be recognised and recorded as a valid contact.

6.3 Registered clients and activity contacts

Previous research (Crane and Warne, 2001a; Shiner and Leddington, 1991) has indicated low numbers of homeless people being registered with local primary health care services. In this study, however, a high proportion of the homeless interviewees were registered with a general practice in the Chester area, with the majority of interviewees being registered with the PMS site for the homeless. Despite the difficulties experienced in accurately recording registrations and activity contacts, it was clear that permanent registrations were increasing. This in itself is a measure of the success of the service.

In addition, it can be seen from the activity contact data that there was a lot of activity in terms of contact with homeless people. It is also clear from the number of individuals seen during the reporting period compared to the number of permanent registrations that the homeless population is of a transient nature, which presents its own challenges when attempting to provide primary care services. Homeless people reported difficulties with complying with prescribed treatments and often failed to return for follow up appointments. Whilst it was recognised by the homeless that such actions could have serious consequences upon their health, it was felt the chaotic nature of their lifestyle made compliance difficult.

The problem of inaccuracies in the recording of activity contacts has been recognised by the PMS site staff and is being addressed through continued staff development. This is an important issue, as without accurate data it will not be possible to truly reflect the amount of work undertaken by the PMS site and the PHCT as the client base continues to grow. Such under-representation could ultimately affect decision making and the distribution of resources for the homeless.

6.4 Health problems experienced by the homeless

It was evident from this study that many of the health problems experienced by those homeless in Chester were similar in nature to those identified in other research (e.g. O'Connell, 2004). Homeless interviewees referred to a wide range of medical complaints which they were concerned about. Furthermore, in the majority of cases, it was expressed by interviewees that their quality of health had deteriorated since becoming homeless: for some resulting in strokes or heart attacks. Whilst heart attacks and strokes were highlighted, it was the smaller problems that gave greater concern, for example basic hygiene, head lice and bad feet. Both members of the PHCT and homeless interviewees referred to bad feet as a recurring problem, often caused by the continual wear of the same footwear. Attempts to address this issue were made through the work of the social and health care worker who completed foot checks as part of a check-up when working alongside the doctor, especially for those who were sleeping rough. This highlights the importance of simple care measures which could potentially have a big impact on individual homeless people.

At the time of the study, 26% of clients registered with the PMS site were recorded as having alcohol dependency. Males had greater levels of alcohol dependency than females, with few women recorded as alcohol dependent (29% males, 16% females). Such findings were below the levels reported by Bunce (2000), who reported 56% of homeless males had alcohol problems. The highest

numbers of homeless people with alcohol dependency were within the 25 – 34 age group. However, evidence from the quantitative data suggests that a higher percentage of homeless people from older age groups are likely to have problems with alcohol dependency. When examining those who were registered as drug dependent, the percentage of females with drug dependency was similar to the levels recorded amongst males (48% males, 42% females). In contrast to alcohol dependency, the greater proportion of drug dependent clients were found amongst the younger age groups. A decline in drug dependency can been seen through the age groups, with no clients aged 55 – 64 with drug dependency. From the qualitative data, it would appear drugs are a greater problem than alcohol amongst the homeless in Chester. Therefore, concentrating drug services on those younger people who find themselves homeless could prove beneficial in an attempt to reduce dependency levels.

The need to reduce the levels of drug dependency is two fold. Firstly, there is the issue of the individuals' immediate and long term health. Secondly, the problems faced by those professionals who work alongside the homeless under the influence of drugs. As highlighted by homeless support workers, when working with a homeless person who is under the influence of drugs, even the most simple of tasks in order to provide shelter for the evening can be made complicated. As a result this can ultimately affect the level of support provided.

Further concerns over drug and alcohol dependency are also raised with the high levels of dependency amongst those who suffer mental health problems. Seventy percent of those referred with mental health problems were reported to have drug and/or alcohol dependency problems. The high levels of alcohol and drug dependency amongst those with mental health problems may be worthy of further investigation.

6.5 Accessibility of care

To deliver appropriate and accessible primary health care services to homeless people was one of the three main objectives of the PMS site, and it was this that the current study particularly sought to explore. Previous research has highlighted the issue that homeless people tend to consult GPs and primary care services infrequently (Power et al, 1999; Crane and Warne, 2001a). However, it was perceived by all of the homeless interviewees, members of the PHCT and the homeless support workers that the accessibility of primary care services for homeless people in Chester was excellent. Indeed, for those interviewees who had been homeless in other towns and cities, or had knowledge of service provision in other localities, the provision of primary care services for the homeless in Chester were perceived as more accessible and with greater levels of support.

In terms of why the service was so accessible, both the homeless and the professional interviewees articulated the view that it was largely to do with the nature of the services provided, in the form of drop in sessions at the day centre and surgery appointments. Drop in sessions at the day centre allowed the homeless person to attend with no appointment and place their name on a list to be seen, this allowing them to wait and to be seen in an environment they were familiar with. The surgery appointments were conducted at St. Werburgh's practice, a site set up particularly to serve the homeless population. Both the drop in sessions and the surgery specifically for homeless people served to encourage those who needed medical treatment to seek help and allowed them to avoid the anxiety often associated with mainstream medical practices (Bunce, 2000).

Another reason suggested for the perceived accessibility of primary care services was the clear signposting from homeless support agencies. The issue of

support from additional agencies will be explored further within the section in this Chapter concerning multi-agency working.

Homeless people and homeless support workers perceived the attitude of the PHCT as having a decisive impact on the homeless accessing primary care services. The ability to understand the issues surrounding homelessness, and the approach of PHCT members who were prepared to spend time with the homeless and listen to their problems, was believed to be a key reason for the willingness of the homeless to access primary health care services. Previous research (Shiner and Leddington, 1991) has identified how the homeless often feel looked down upon by doctors, nurses and receptionists, often resulting in those in need of treatment failing to receive the attention they require. As a result of failing to access primary health care, homeless people often wait until crisis point, attending accident and emergency services (ODPM, 2003). Within the current study, homeless people expressed the view that the PHCT were very supportive and non-judgemental of their situation. Such an approach was perceived as critical in building relationships with the clients. As a result, this made homeless people more inclined to discuss their problems and emotions and use the service again. It was not possible, from this study, to say whether the development of primary care services has had an impact on the local A and E services, but this may be an area worthy of investigation.

Some limitations to the way in which homeless people were able to access primary health care services were identified by interviewees. Firstly, as in previous research (Reily et al, 2003; Crane and Warne, 2001a) the current study identified the chaotic nature of the lifestyle amongst many homeless people, combined with their low prioritisation of health and inability to recognise the severity of some health problems. These factors all led to homeless people accessing primary care services less frequently than might be optimal. Despite this, homeless interviewees recognised that taking responsibility for their own

health was their own responsibility and an issue which they needed to address, and that primary health care was readily available in Chester.

Secondly, it was recognised by professionals that those people who are homeless but do not move in the circle of the homeless (i.e. use hostels, the day centre or the night shelter) are potentially marginalised from the primary health care service, making them more vulnerable to the poor health associated with homelessness (O'Connell, 2004). However, with the co-operation of additional agencies that potentially come into contact with the homeless greater levels of 'signposting' to the primary care services available could be provided. For example, it was suggested that the police could carry and distribute a credit card sized information card outlining the available support services for the homeless. This could potentially direct homeless people who came into contact with the police towards support services available to them. Whilst this would not guarantee primary care was received, it would serve to increase the awareness of both primary care services and support agencies for the homeless.

6.6 Quality of care

The objectives of the PMS site for the homeless concerned providing appropriate care for this client group. In order to provide appropriate care, it can be argued that care should be of a high quality. In this study, evidence from interviews with homeless people revealed that the quality of care experienced was perceived as excellent. Furthermore, it was articulated that nothing else could be done to improve the quality of care. Professionals also expressed the view that high quality care was available.

It was recognised by both homeless people and homeless support workers that the attitude of the staff involved in providing primary care had a decisive impact on the quality of care. One reason for the perceived high quality of care was the length of time afforded to patients in consultations. The PHCT

articulated the view that they would spend as long as necessary with a client in order to establish the cause of their problem and the most appropriate way forward. Often clients come with the sole intention of receiving drugs for pain management which was not always appropriate. However, by handling the client sensitively, with time spent explaining issues, clients could gain an appreciation of their treatment. Through such an approach it was hoped clients would have a greater understanding of their problems and the recommended course of treatment. Through having the time to spend with clients health care professionals were able to build up a rapport with the client. Such a rapport would appear to be an essential ingredient in the client – professional relationship that is often reported as missing in mainstream practices who provide primary care to the homeless (Partis, 2003).

It was recognised by homeless interviewees that the treatment provided by the PHCT was in their best interest. Despite the introduction of the PMS site and despite the numerous sessions available for the homeless to attend, this still could not guarantee that homeless people would return for follow up appointments or indeed follow a prescribed course of treatment. There was evidence in this study from interviews with homeless people themselves who recognised the serious consequences of failing to follow any course of action decided upon by the PHCT. Despite realising the possible effect upon the quality of their health and ultimately life, they were still unable to guarantee to compliance. Despite the excellent service provided the homeless person still has to comply with the course of treatment and no form of service can guarantee that.

6.7 Multi-agency working

Within this study there was evidence of effective working partnerships between the PHCT and homeless support services. It was recognised by homeless people that homeless support workers played a significant role in encouraging and

supporting those who were living in hostels and/or using the day centre to access primary health care services. Such support could even include homeless support workers attending appointments with homeless clients to provide moral support. Without such support some homeless individuals may not have accessed the available primary care services.

The benefits of multi-agency working were further highlighted by homeless support workers. If a homeless person presented themselves to one of the support services, and it was deemed by staff they were in need of medical attention, staff were able to arrange an appointment for the homeless person with the PHCT on the same day. This was especially welcomed for those homeless people who were believed to be suffering from mental health issues. Whilst the difficulty in accessing mainstream mental health services has been documented (Crane and Warnes, 2001; Holland, 1996), homeless support workers were able to arrange a visit from the PMS pilots MHSP, often within a matter of hours. As a result support workers were able to work with homeless people safe in the knowledge they were not a risk to themselves, the support worker or others around them. Such a collaborative approach between primary care services and homeless support services was beneficial in aiding those homeless people in need of medical attention to access primary care services.

As previously alluded to by a homeless support worker links with additional agencies that come into contact with the homeless, like the police force, should be actively sought, encouraged and developed. Through the distribution of information cards to such agencies attempts could be made to reach those homeless people who do not move in the circles associated with the homeless, potentially increasing the awareness of the primary care and support services available.

6.8 Constraints on service provision

Interviewees found it difficult to identify constraints on service provisions. Primary health care staff expressed the view that if the numbers of homeless people residing in Chester increase to a great extent, then areas of the service, for example the MHSP, would not be able to handle the potential workload following the long term absence of one team member.

Evidence from the quantitative data indicates there has been a continual increase in the number of homeless people registering with the PMS site. Over the 22 months for which data were available there was an increase in the number of homeless people registered with the service from 104 to 150. There was also an increase in the monthly activity contacts over the 22 month period from 110 to 238. One reason for the continual increase in the numbers of homeless people registered could be due to the work conducted by the PMS pilot PHCT and the homeless support agencies for those who reside in Chester. For example, the outreach programme for prisoners due for release who intend to return to the Chester area and who have no accommodation are actively supported. As a result of such support, those prisoners who will find themselves homeless upon release may be encouraged to come to Chester as it appears to be a city that provides support for those who are homeless. However, another reason for the increase in registrations and activity contacts could be due a large number of people who were already homeless in Chester registering with the service. Reasons behind the increase in homeless registration and why people find themselves residing in Chester may be an area worthy of further investigation.

6.9 Developments

Primary care services would appear to be perceived as largely adequate by interviewees, with help available for those who chose to access the services and accept the help offered. Two areas were perceived as possible areas for

development. Firstly, health promotion, including sexual health and family planning, was identified as an area requiring development. However, although this matter had been identified as an area for development, due to long term staff illness it had not been possible to fully address the issue. Development of health promotion services was expected to occur once the PHCT returned to a full complement of staff. Secondly, counselling was also seen as an area for development by all professionals. Again, although this had been recognised, funding had not been secured to provide counselling services for the PMS site. A member of the PHCT was qualified as a counsellor and could undertake this role, but, problems surrounding contractual issues were holding up the development of the counselling services. A solution to the problem was being sought for this perceived much needed addition to the service.

A further area of potential development identified by a member of the PHCT was the targeting of young individuals who had just been made homeless and were living in temporary accommodation, individuals who had not necessarily got as far as drug use in a major way. Through the targeting of such individuals with health promotion, and again using a multi-agency approach, it was hoped proactive measures could help those individuals before they reached crisis point and required major interventions associated with homelessness (Crane and Warnes, 2001a).

Other suggested areas for development were outside of the normal primary care remit. One suggestion included an increase in accommodation, especially for those who were leaving hospital with no guarantee of accommodation. Such individuals were forced to sleep on the streets, often causing a rapid deterioration in health and re-admittance to hospital. Whilst providing accommodation was not an aim or objective of the PMS site, the consequences of sleeping rough when unfit to do so ultimately places additional demands upon primary care and other NHS services. Another area highlighted was the possible

development of life skills classes. Homeless interviewees felt sessions on nutrition, cooking, first aid and basic hygiene could considerably help their health. Such sessions were also highlighted by homeless support workers, although it was felt that the majority of homeless people would probably be disinterested. However, nutrition for those living in hostels was perceived as a useful exercise to promote healthy living. Such support session could be beneficial as a lack of knowledge in aspects such as nutrition and hygiene has been previously reported (Power et al, 1999). As these suggestions for development highlight, there is a need to continue with multi-agency working to ensure that the wide range of needs, which include primary care for the homeless, are met.

6.10 Conclusions

Evidence from quantitative data presented in the study indicates that increasing numbers of homeless people are being registered with and using the services provided by the PMS pilot site for the homeless in Chester. These are people who could potentially be excluded from mainstream primary health care. Although it is not possible to know what proportion of all homeless individuals in Chester access these primary care services, there was evidence in this study of excellent opportunities for services to be obtained in a variety of settings. Through the introduction of a surgery set up specifically with the homeless in mind, and primary care services being available at the day centre, where many of the homeless congregate, it would appear an ideal option for those who dislike or fear traditional primary care services to access medical treatment. Furthermore, the positive and caring attitude of the PMS site staff would appear to encourage potential users to access the available services.

Effective partnership working between the PMS site staff and homeless support workers was evident in this study. Such collaborations enable those homeless people in need of medical attention to gain access to primary care services,

whilst providing reassurance for homeless support workers regarding the health of the homeless and their own personal safety. The continual development of multi-agency work can only serve to help those who find themselves homeless in Chester to access primary medical services. However, the problem is often those who do not seek help, putting off seeking treatment until the problem reaches crisis point. Therefore, it is important to continue to attempt to work with additional agencies in order to reach those homeless people who do not ordinarily move in the circles of the homeless.

Suggested developments to the service were generally broader than that incorporated in the traditional remit of primary care services. Such suggestions included education for the homeless people around nutrition, cooking, and first aid. In addition, the need for increased levels of accommodation for those just leaving hospital was highlighted. Such suggestions underline the importance of multi-agency working to help ensure the needs of the homeless are being met. Plans have been made to develop health promotion services, including sexual health and family planning, in line with the objectives of the PMS pilot. Therefore, it appears a holistic approach is being taken in meeting the primary health care needs of the homeless in Chester and that the PMS pilot site is achieving its objective of delivering appropriate and accessible health care services to homeless people.

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Appendix 1

Professional participants' information sheet

Participant Information Sheet
Evaluation of Primary Care Services for homeless people in Chester

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to evaluate the extent to which the Chester City homeless personal medical services (PMS) pilot has met the needs of the homeless population by providing primary care services. This study aims to explore the views and experiences of homeless people who have and have not accessed the services, along side that of professionals, in relation to a variety of issues:

- Individuals' perceptions of need and the extent to which these have been met
- Accessibility of the service.
- Comparability of the service to any primary care services accessed in the past.
- The views and experiences of members of the primary health care team (PHCT) in relation to the ways in which the PMS pilot provides accessible care that meets the needs of the homeless population;
- Views of other professionals who work locally with the homeless population.

We are interested in the way the service is delivered, how this is meeting the primary care needs of the homeless, the advantages and disadvantages of the current service and how this could be improved. This information can then be used to assist in developing and improving services.

Why have I been chosen?

- You have been chosen because you are a professional involved in delivering services to homeless people.

Do I have to take part?

It is up to you whether or not you take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you decide to take part you should keep this information sheet and sign the consent form. The researcher will be conducting interviews with professionals and homeless people. The interviews will last about 30 minutes and with the permission of participants may be audio taped.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks foreseen in taking part in the study.

What are the benefits to taking part?

From sharing your previous experiences with regards to accessing health care services, it may help to improve service provision in the future.

Will my taking part in this study be kept confidential?

Taking part in this study is anonymous and no names or details that could identify you would ever be used is any verbal or written report of the study.

What will happen to the results of the research study?

It is hoped that the results will be used to improve and develop services for homeless people in Chester. A written report will be produced, but as already stated nobody who takes part in the study will be identifiable.

Who is organising and funding the research?

The research is being funded by Cheshire West Primary Care Trust. Researchers from the Centre for Public Health Research, University College Chester, are carrying out the study.

Who may I contact for further information?

If you would like more information about the study before you decide whether or not you would be willing to take part, please contact either Simon Alford or Catherine Perry on 01244 220364 or write to them at the Centre for Public Health Research, University College Chester, Parkgate Road, Chester, CH1 4BJ.

Thank you for your co-operation in this research. Without your help we could not know what the community and professionals think about the support available to homeless people.

Appendix 2

Participants' consent form

(form to be on headed paper)

Consent form

Title of project: **"Providing health care for the homeless population: An evaluation of Chester City Homeless PMS pilot"**

Name of Researcher: **Simon Alford**

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason. ☐

3. I agree to take part in the above study. ☐

Name of Subject	Date	Signature
Name of person taking consent (If different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 3

PHCT interview schedule

Interview Schedule for PHCT staff working alongside homeless people

General Background

- Could you tell me about your role and responsibilities in relation to the PHCT PMS pilot and working with homeless people?

- Do you work with other professionals in providing primary care to the homeless?

If yes- Who?
What is their role?

- Could you tell me about the development of the Chester City homeless PMS pilot and the reasons why it was set up?

Current work with homeless people

- What do you see as the primary health care needs of the homeless in Chester

Prompt- any reoccurring problems
factors that affect these i.e. seasonal

- What impact do you think that the PMS pilot has had on the quality of primary care for homeless people?

Prompt- In terms of the number of patients accessed/ accessing services

problems with the demands placed upon services and personnel working to provide these services.

- What impact do you think the PMS pilot has had on health outcomes for homeless people?

Prompt- How far do you believe the needs of homeless people have been met?

- How would you define high quality primary care for homeless people?

- What factors, if any, enable you to provide high quality care to the homeless?

- What factors, if any, hinder you in trying to provide high quality care for the homeless?

- Do you see any gaps in the services provided

Prompt- counselling services?

Prompt - If yes - how these could these be overcome?
Would organisation/administrative changes help?

- At present how successful do you think the services are meeting the needs of homeless people

Prompt- What do you feel that the service does well?

What do you attribute this success to?

What do you think is not done so well?

How could this be improved?

The future of primary care services for the homeless

- How do you see perceive services developing in the future?

- If you could describe what you perceive to be the perfect primary care service for homeless people in Chester, what would it look like?

Prompt- What would you like to see happen?
What would prevent such developments occurring?

Thank you for answering these questions

Appendix 4

Homeless support workers' interview schedule

Interview Schedule for professionals working alongside homeless people

General Background

- Could you tell me about your role and responsibilities in relation to working with homeless people?

- Can you explain the links you have with GP's and the service they provide?

- Do you work with any other services to help provide primary care/care to help the homeless?

If yes- Who?
What is their role?

- Do you know anything about the development of the Chester City homeless PMS (personal medical service) pilot and the reasons why it was set up?

Current work with homeless people

- What do you see as the primary health care needs of the homeless in Chester

Prompt- any reoccurring problems
factors that affect these i.e. seasonal

- What impact do you think that the PMS pilot has had on the quality of primary care for homeless people?

Prompt- In terms of the number of patients accessed/accessing services

- What impact do you think the PMS pilot has had on health outcomes for homeless people?

Prompt- How far do you believe the needs of homeless people have been met?

- How would you define high quality primary care for homeless people?

- What factors, if any, enable the provision of high quality care to the homeless?

- What factors, if any, hinder the provision of high quality care for the homeless?

- Do you see any gaps in the services provided

Prompt- counselling services?

Prompt - If yes - how these could these be overcome?
Would organisation/administrative changes help?

- At present how successful do you think the services are meeting the needs of homeless people

Prompt- What do you feel that the service does well?

What do you attribute this success to?

What do you think is not done so well?

How could this be improved?

The future of primary care services for the homeless

- How do you see services developing in the future?

- If you could describe what you see to be the perfect primary care service for homeless people in Chester, what would it look like?

Prompt- What would you like to see happen?
What would prevent such developments occurring?

Thank you for answering these questions

Appendix 5

Homeless participants' information sheet

Participant Information Sheet
Evaluation of Primary Care Services (GP and nurses) for homeless people in Chester

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The purpose of the study is to evaluate the extent to which GP's and nurses have been able to meet the needs of the homeless population in Chester by providing primary care services. This study aims to explore the views and experiences of homeless people who have and have not accessed the services, in relation to a variety of issues:

- Individuals' perceptions of need and the extent to which these have been met
- Accessibility of the service.
- Comparability of the service to any primary care services accessed in the past.

We are interested in the way the service is delivered, how this is meeting the primary care needs of the homeless, the advantages and disadvantages of the current service and how this could be improved. This information can then be used to assist in developing and improving services. Taking part or deciding not to take part will not change the care that you receive from the GP and nurse in Chester

Why have I been chosen?

- You have been chosen because you are a person who is currently homeless.

Do I have to take part?

It is up to you whether or not you take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you decide to take part you should keep this information sheet and sign the consent form. The researcher will be conducting interviews with professionals and homeless people. The interviews will last about 30 minutes and with the permission of participants may be audio taped.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks foreseen in taking part in the study.

What are the benefits to taking part?

From sharing your previous experiences with regards to accessing health care services, it may help to improve service provision in the future.

Will my taking part in this study be kept confidential?

Taking part in this study is anonymous and no names or details that could identify you would ever be used is any verbal or written report of the study.

What will happen to the results of the research study?

It is hoped that the results will be used to improve and develop services for homeless people in Chester. A written report will be produced, but as already stated nobody who takes part in the study will be identifiable.

Who is organising and funding the research?

The research is being funded by Cheshire West Primary Care Trust. Researchers from the Centre for Public Health Research, University College Chester, are carrying out the study.

Who may I contact for further information?

If you would like more information about the study before you decide whether or not you would be willing to take part, please contact either Simon Alford or Catherine Perry on 01244 220364 or write to them at the Centre for Public Health Research, University College Chester, Parkgate Road, Chester, CH1 4BJ.

Thank you for your co-operation in this research. Without your help we could not know what the community and professionals think about the support available to homeless people.

Appendix 6

Homeless participants' interview schedule

Interview Schedule for Homeless people

General Background

- Where are you currently living?

- How long have you lived there?

Prompt- is this the 1st time you've been homeless, when?
Do you or have you ever slept rough?
When, how often, why?

Your health in general and care/treatment you receive

- Do you have any worries or concerns about your health at the moment?

Prompt – what kind of physical health problems do you have? (If have worry/concern) – give examples e.g. breathing or chest problems, headaches, skin sores or conditions, pain or aches in muscles or bones.

If any - What kind of treatment or care have you had for these health problems?

Has this care helped with you problems?

Is there anything that you did not get that you think might have helped?

Use of primary care services generally

- Are you registered with a GP at the moment? (local GP?)

- How easy is it for you to see a GP at the moment?

Prompt- Do you always see the GP you are registered with (if registered)

If any - Describe problems you may have seeing a GP or nurse at the surgery affect of problems on you
- Feelings
- What did you do?

- Do you think that people in your situation sometimes have problems in seeing a GP or nurse when they need one?

- What or who has helped you to access a GP or nurse in the past if you have concerns about your health?

Prompt- if Yes, How does this help
If no, who could help ~ resettlement workers
~ hostel worker
~ outreach worker

- What sort of things would improve accessing a GP?

Prompt (if necessary)
- Venue i.e. appropriate
- Time of day
- Availability of appointment vs. drop-in
- Attitudes of public and staff

Use of PMS services (may need to explain PMS site and services)

- Have you used any of the services at the PMS site (George St Practice, Dr Dennis)

Prompt - which services used
What problems if any

If yes - Was it helpful? - Why?
Could it be improved? - How?
Why would that help?

- Have you used hospital services?

Prompt- which services used
What problems if any

- What kind of services do you use most often?

Prompt - Health Services, like A&E your GP, or Drop in services for homeless people, churches etc?

- Why is this?

Prompt - don't need the other services?
- Difficulty in accessing them & if YES, Why?
- Don't like appointments
- Or other priorities – e.g. getting something to eat & somewhere to stay

Changes in the future

- What could help you to use all the services you require?

- What would the perfect GP service for you be like?
  Drop in, time of day etc etc

Thank you for answering these questions